Milwaukee WIser Choice

GUIDELINES FOR USE OF DISCHARGE CODES

Client discharge is required whenever an Episode of Care ends for a particular client. (This differs from a client Enrollment, which may involve several episodes of care, concurrent or sequential, from providers of different services.) An Episode of Care represents the continuous service of one kind—for clinical providers, at a single Level of Care—provided to a single client by a single agency, regardless of how long services of this kind continue. An Episode of Care begins with admission, which is dated as the first service provided (or first service at a specified Level of Care); it ends when the provider determines that no more services of that kind for that client are to be billed to WIser Choice by that provider. Discharge may be accomplished through the online billing system or by submission of a paper Discharge Form.

The State of Wisconsin mandates that we use certain discharge codes, but these codes have at times been interpreted differently by different providers, and single categories have been employed to represent aggregates of two or more different types of clients. Though we must continue to classify discharges according to the State categories, our new discharge codes include subcategories (those with both a number and a letter) to help make the coding of Episode of Care discharges more consistent throughout the WIser Choice system.

Closing Reason

1. Completed Service/Treatment

   Use one of the "Completed Service/Treatment" codes only when a client is ending BOTH an episode of services at a particular level of care AND his/her current enrollment in Milwaukee WIser Choice (at any level of care). If the client is to continue to receive Milwaukee WIser Choice services at this time, choose one of the options under "Transfer/Referral-AODA Pgm" or "Transfer to Another Provider."

   1A. No more services needed

   Use this category if the client is expected to be able to maintain her/his recovery with the assistance of informal supports. No further treatment is needed or recommended at this time.

   1B. Maximum benefit obtained

   Use this category when the client has obtained as much value from continued treatment as possible for the client under her/his present

circumstances. Include in this category clients for whom further treatment at this time (at any level of care) is unlikely to significantly improve the client's chances of eventually maintaining her/his recovery with informal supports. Also include clients who withdraw from treatment due to a perceived need to attend to employment, child care, family or health issues. Exclude from this category clients who leave because they reject or disagree with staff advice that they would benefit from additional treatment.

2. Referred-Nonalcohol/Drug Program

Use this category for clients referred to a hospital for ailments that need to be addressed in a non-AODA context, including referrals to PCS or to BHD mental health or other mental health services.

3. Terminated – Rule Violation

Use this category for clients whose violations of provider agency rules warrants their discharge, including those who might have success with another treatment provider. Briefly describe the nature of the rule violation in the space provided. Include in this category clients discharged for violations who have been referred or transferred to other agencies for treatment. Exclude clients whose violations of their conditions of legal supervision—including failure to comply with treatment—have resulted in incarceration.

4. Withdrew Against Staff Advice

Use this category only for clients who have chosen to withdraw from treatment in spite of having been advised by the provider that they would benefit from additional treatment (at either this or another level of care). Include in this category those "passive withdrawals" the provider agency has been able to contact and schedule services but who repeatedly fail to participate in services. Exclude from this category "passive withdrawals" who have repeatedly missed appointments but who can no longer be contacted and/or are non-responsive to telephone or mail communications; these should be coded as "Unable to Locate."

5. Funding/Authorization Expired

5A. SAR for continuation denied

Use this category for clients for whom continued services have been requested but for whom a Service Authorization Request has

been denied (regardless of whether the denial was due to clinical or fiscal reasons).

5B. System-wide funding limitation

Use this code for clients who fall into client categories for which funding has been restricted due to budget issues (as, for example, if all Day Treatment clients must be transferred to Outpatient and/or all Outpatient clients are allowed only one 30-day continuation of services.) Note this subcategory is used only when large numbers of clients are restricted, not for a unique individual case.

6. Incarcerated for New Offense

Use this category for clients whose treatment is terminated due to incarceration when it is also known the incarceration was due to an offense committed while the client was enrolled in treatment.

7. Death

Use this category for clients who are dead.

8. Transfer/Referral-AODA Pgm.

8A. Same provider, new Level of Care

Use this category for clients being discharged from a Level of Care within a provider agency who are being transferred to another Level of Care within that same provider agency (regardless of location). Note that each client must be discharged from each Level of Care episode even when the client's enrollment continues and even when the agency continues to provide her or his treatment.

8B. Same provider, new funding source

Use this category for clients for whom the availability of alternative funding has allowed them to be discharged from Milwaukee WIser Choice but who will continue to receive treatment paid for by the alternative source. Include clients who will continue treatment funded by the Intoxicated Driver Program (IDP), which formerly fell under a different code. Exclude from this category clients who had to be switched to another funding source because a WIser Choice Service Authorization Request was denied.

9. Unable to Locate Client

Use this category for clients about whom the provider agency does not have sufficient knowledge to judge the reason they are not receiving treatment: that is, when the provider agency does not know if the client has moved, has been incarcerated, has relapsed, has concluded the treatment is not helping them, or who considers her- or himself to have successfully completed treatment. Include in this category "passive withdrawals" who have repeatedly missed appointments but who can no longer be contacted and/or are non-responsive to telephone or mail communications.

10. Transfer to Another Provider

9A. New provider, same Level of Care

Use this category for clients being discharged from a provider agency because they are being referred to another agency for treatment at the same Level of Care. However, exclude from this category cases in which the client's violation of provider agency rules has resulted in this transfer; instead, code these cases as "Terminated—Rule Violation."

9B. New provider, new Level of Care

Use this category for clients being discharged from a Level of Care within a provider agency who are being transferred to another Level of Care at a different provider agency.

11. Incarcerated for Old Offense

Use this category for clients whose treatment is terminated due to incarceration when it is also known the incarceration was *not* due to an offense committed while the client was enrolled in treatment. Include clients on probation or parole who were incarcerated (or re-incarcerated) due to violations in the conditions of legal supervision, including failure to comply with treatment. Include in this category clients who were awaiting trial for an offense committed prior to admission to treatment who are eventually incarcerated as a result of that prior offense.

Level of Improvement

1. Major improvement

    - Amount, duration and participation in services consistent with the treatment plan.
    - Satisfactory or more than satisfactory progress on individualized treatment/ recovery plan goals.
    - Significant reduction in symptoms that were present just prior to admission.
    - Discharge/aftercare/continuing care/relapse prevention plan developed and agreed upon.
    - Good motivation for recovery.
    - Good progress in sustained recovery.

2. Moderate improvement

    - Amount, duration, and participation in services consistent with or nearly consistent with the treatment plan.
    - Satisfactory or nearly satisfactory progress on individualized treatment/ recovery plan goals.
    - Some reduction in symptoms that were present just prior to admission.
    - Discharge/aftercare/continuing care/relapse prevention plan developed and agreed upon.
    - Average motivation for recovery.
    - Fair or guarded prognosis for sustained recovery.

3. Unchanged

    - Amount, duration, and participation in services may be consistent with or not consistent with the treatment plan.
    - Less than satisfactory progress on individualized treatment/ recovery plan goals.
    - Little or no reduction in symptoms that were present just prior to admission.
    - Discharge/aftercare/continuing care/relapse prevention plan not agreed upon.
    - Low or inconsistent motivation for recovery.
    - Poor prognosis for sustained recovery.
    - Needs further treatment.

4. Worsened

- Amount, duration, and participation in services not consistent with the treatment plan.
- Less than satisfactory progress on individualized treatment/ recovery plan goals.
- Increase, worsening, or deterioration of symptoms that were present just prior to admission.
- Discharge/aftercare/continuing care/relapse prevention plan not agreed upon.
- Little or no motivation for recovery.
- Relapse-prone.
- Needs further treatment.

Additional Fields

The Discharge Form allows providers to specify a Recommended Next Level of Care (LOC). Entering this information into CMHC helps BHD Administrative Coordinators and others to follow up as needed on a client that may continue to receive services after discharge from a provider or from a particular level of care.

The Explanation field is required whenever the Closing Reason is Termination for Rule Violation; it may be used for optional explanatory comments at other times.

When entering discharges into CMHC, after the “Save” button is hit, the system takes you to the Client Contact Information screen. It is not organized exactly the same way as the paper discharge form, but should be used for the same purpose: to indicate the best known way to contact the client after discharge.